



To apply in person please visit our office at 5855 Olivas Park Drive, Ventura, CA 93003
Monday – Friday, 9:00 am – 4:00 pm

**REQUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE / DISCOUNT PAYMENT PROGRAM
APPLICATION INSTRUCTIONS**

Date: _____

Patient Name: _____

Account Number(s): _____

Total Balance for Consideration: \$ _____

This application is for Community Memorial Hospital charges only.

All physicians including Community Memorial Health Centers physicians, radiologists, pathologists, anesthesiologists, emergency room physicians and ambulance services are billed separately from Community Memorial Hospitals and are not covered by this application.

The hospital may only request recent paystubs or income tax for documentation of income. The hospital may accept other forms of documentation of income but shall not require such other forms.

It is important that the application be complete, and all requested information is provided in order to properly assess your ability to pay all or part of the hospital bill.

Although we do not require a completed Medi-cal application to determine your eligibility; it is recommended that you complete a Medi-cal screening to offset any additional charges that is not covered by this application. If you choose to do so, you can contact the local Department of Health Services at 888-472-4463 or <https://benefitscal.com>

The following documents are required to process your application:

- (1) Fully completed charity care/discount payment program application (enclosed with this letter)
- (2) A copy of your most recent period payroll check stubs. Note that this also includes public assistance (for example, Social Security, Unemployment, or Disability). If you receive your income in cash, please provide us with a written statement from your employer stating your income.

If you currently are not receiving any income please write a brief paragraph on a separate sheet of paper stating your current financial situation. Be sure to include the date and signature. If you are receiving financial assistance or living with someone, please have him or her write a statement explaining the situation.

- (3) Rent or mortgage verification. (Required if seeking a discount payment plan)



(4) Optional: A copy of your prior year's tax return (the completed and signed 1040)

Please send copies of these documents because they will not be returned to you.
If you have any questions, please telephone me directly at 805-948-5615 for assistance.

Thank you,

Patient Financial Services Department
Community Memorial Healthcare



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**REQUEST FOR FINANCIAL ASSISTANCE
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APPLICATION**

Patient Name: _____

Patient Account Number(s): _____

Guarantor Name _____

Date of Birth: _____ SS# _____ - _____ - _____

Phone: () _____

Address: _____

City, State, Zip: _____

Spouse Name: _____ SS# _____ - _____ - _____

Are you a U.S. Citizen? ___ Yes ___ No

If not, a resident alien? ___ Yes ___ No

If not, non-resident alien? ___ Yes ___ No

FAMILY STATUS: List all dependents who you support

Name	Age	Relationship
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____

If self-employed, Name of business: _____

Employer Address: _____

Phone Number: _____ How long employed: _____

Spouse Employer: _____ Position: _____

If self-employed, name of business _____

Statement of Current Income and Expenditures
Current Monthly Income

	<u>Patient</u>	<u>Spouse</u>
Gross Pay	\$ _____	\$ _____
Income from business (if self-employed)	\$ _____	\$ _____
Interest and dividends	\$ _____	\$ _____
Income from real estate or personal property	\$ _____	\$ _____
Social Security/Retirement Income	\$ _____	\$ _____
Alimony, support payments	\$ _____	\$ _____
Unemployment compensation	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
Total Monthly Income	\$ _____	\$ _____

Current Monthly Expenses

	<u>Patient</u>	<u>Spouse</u>
Rent or House Payment	\$ _____	\$ _____
Real Estate Taxes	\$ _____	\$ _____
Utilities	\$ _____	\$ _____
Alimony, support payments	\$ _____	\$ _____
Education	\$ _____	\$ _____
Food	\$ _____	\$ _____
Payroll Deductions	\$ _____	\$ _____
Medical, dental and medicines	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Total Monthly Expenses	\$ _____	\$ _____

